Programs (Guidelines/Limitations)

Office and Other Outpatient Services [Refer to WAC 388-531-0950]

In addition to the limitations on services indicated in the fee schedule, the following limitations apply:

The Department of Social and Health Services (the Department) covers:

- One office or other outpatient visit per non-institutionalized client, per day for an individual provider (except for call-backs to the emergency room per WAC 388-531-0500).

  ✓ Certain procedures are included in the office call and cannot be billed separately.

  Example: The Department does not pay separately for ventilation management (CPT®) codes 94002-94004, 94660, and 94662) when billed in addition to an Evaluation and Management (E&M) service, even if the E&M service is billed with modifier 25.

- One pre-operative E&M procedure by a physician for a dental client **prior to performing dental surgery**. Bill using dental diagnosis codes 520.1–525.9 as the primary diagnosis when billing E&M codes for pre-op services for dental surgery, along with the appropriate pre op diagnosis codes V72.81–V72.84) as the secondary diagnosis. For clients assigned to a Department managed care organization, bill the Department directly for history and physical claims for dental surgery.

- Two physician visits per month for a client residing in a nursing facility or an intermediate care facility. Nursing facility discharges (CPT code 99315 and 99316) are not included in the two-visit limitation. The Department pays for one nursing facility discharge per client, per day.

Office and Other Outpatient Services (cont.)

- One physical examination per client, per 12 months for clients with developmental disabilities as identified in ProviderOne. Use HCPCS procedure code T1023 with modifier HI and an ICD-9-CM diagnosis code from the range V79.3-V79.9 to bill for an examination.

- The Department pays one new patient visit, per client, per provider or group practice in a three-year period.

- Preventative screening services for certain conditions are covered in other sections of these billing instructions.

Children's Primary Health Care **(CPT codes 99201-99215)**

- The Department pays a higher payment rate for primary health care performed in the office setting (CPT codes 99201-99215) for children 20 years of age and younger. These are the only services that are paid at the higher rate.

- If a child who is younger than one year of age **has not been issued** an individual ProviderOne Client ID, use the mother's or the father's ProviderOne Client ID, and put a "B" in the claim notes field. Indicate the child's name, gender, and birthdate in the client information fields. **In addition, when billing for a baby using one of the parents' ProviderOne Client IDs, you must add modifier HA to CPT codes 99201-99215 only** in order for the service to be paid at the higher fee. If the mother is enrolled in a Department managed care plan, newborns will be enrolled in the same managed care plan as their mother.

After Hours

Afterhours office codes are payable in addition to other services only when the provider's office is not regularly open during the time the service is provided. An afterhours procedure billed for a client treated in a 24-hour facility (e.g., emergency room) is payable only in situations where a provider who is not already on-call is called to the facility to treat a client. These codes are not payable when billed by emergency room physicians, anesthesiologists/anesthetists, radiologists, laboratory clinical staff, or other providers who are scheduled to be on call at the time of service. The client's file must document the medical necessity and urgency of the service. Only one code for after hours services will be paid per patient, per day, and a second "day" may not be billed for a single episode of care that carries over from one calendar day.

For example: If a clinic closes at 5pm and takes a break for dinner and then opens back up from 6pm-10pm, these services are not eligible for afterhours service codes.

Note: This policy does not include radiologists, pathologists, emergency room physicians, or anesthesiologists. The Department does not pay these providers for afterhours service codes.

Hospital Inpatient and Observation Care Services

(CPT codes 99217-99239) [Refer to WAC 388-531-0750]

Inpatient admissions must meet intensity of service/severity of illness criteria for an acute inpatient level of care. Admission status changes must be noted in the client's chart.

What is admission status?

Admission status is a client's level of care at the time of admission. Some examples of typical types of admission status are: inpatient, outpatient observation, medical observation, outpatient surgery or short-stay surgery, or outpatient (e.g., emergency room).

Admission status is determined by the admitting physician or practitioner. Continuous monitoring, such as telemetry, can be provided in an observation or inpatient status; consider overall severity of illness and intensity of service in determining admission status rather than any single or specific intervention. Specialty inpatient areas (including ICU or CCU) can be used to provide observation services. Level of care, not physical location of the bed, dictates admission status.

When is a change in admission status required?

A change in admission status is required when a client's symptoms/condition and/or treatment does not meet medical necessity criteria for the level of care the client is initially admitted to. The documentation in the client's medical record must support the admission status and the services billed. The Department does not pay for:

- Services that do not meet the medical necessity of the admission status ordered;
- Services that are not documented in the hospital medical record; and
- Services greater than what is ordered by the physician or practitioner responsible for the client's hospital care.

Inpatient to Outpatient Observation Admission Status Change

The attending physician or practitioner may make an admission status change from inpatient to outpatient observation when:

- The attending physician/practitioner and/or the hospital's utilization review staff determine that an inpatient client's symptoms/condition and treatment do not meet medical necessity criteria for an acute inpatient level of care and do meet medical necessity criteria for an observation level of care;
- The admission status change is made prior to, or on the next business day following, discharge; and
- The admission status change is documented in the client's medical record by the attending physician or practitioner. If the admission status change is made following discharge, the document must:
  - ✓ Be dated with the date of the change; and
  - ✓ Contain the reason the change was not made prior to discharge (e.g., due to the discharge occurring on the weekend or a holiday).

Outpatient Observation to Inpatient Admission Status Change

The attending physician or practitioner may make an admission status change from outpatient observation to inpatient when:

- The attending physician/practitioner and/or the hospital's utilization review staff determine that an outpatient observation client's symptoms/condition and treatment meet medical necessity criteria for an acute inpatient level of care;

- The admission status change is made prior to, or on the next business day following, discharge; and

- The admission status change is documented in the client's medical record by the attending physician or practitioner. If the admission status change is made following discharge, the documentation must:

  ✓ Be dated with the date of the change; and
  ✓ Contain the reason the change was not made prior to discharge (e.g., due to the discharge occurring on the weekend or a holiday).

Inpatient or Outpatient Observation to Outpatient Admission Status Change

The attending physician or practitioner may make an admission status change from inpatient or outpatient observation to outpatient when:

- The attending physician/practitioner and/or the hospital's utilization review staff determine that an outpatient observation or inpatient client's symptoms/condition and treatment **do not** meet medical necessity criteria for observation or acute inpatient level of care;

- The admission status change is made prior to, or on the next business day following, discharge; and

- The admission status change is documented in the client's medical record by the attending physician or practitioner. If the admission status change is made following discharge, the documentation must:

  ✓ Be dated with the date of the change; and
  ✓ Contain the reason the change was not made prior to discharge (e.g., due to the discharge occurring on the weekend or a holiday).

Outpatient Surgery/Procedure to Outpatient Observation or Inpatient Admission Status Change

The attending physician or practitioner may make an admission status change from outpatient surgery/procedure to outpatient observation or inpatient when:

- The attending physician/practitioner and/or the hospital's utilization review staff determine that the client's symptoms/condition and/or treatment require an extended recovery time beyond the normal recovery time for the surgery/procedure and medical necessity for outpatient observation or inpatient level of care is met;

- The admission status change is made prior to, or on the next business day following, discharge; and

- The admission status change is documented in the client's medical record by the attending physician or practitioner. If the admission status change is made following discharge, the documentation must:

  ✓ Be dated with the date of the change; and
  ✓ Contain the reason the change was not made prior to discharge (e.g., due to the discharge occurring on the weekend or a holiday).

Note: During post-payment retrospective utilization review, the Department may determine the admission status ordered is not supported by documentation in the medical record. The Department may consider payment made in this circumstance an overpayment and payment may be recouped or adjusted.

The Department covers:

- One inpatient hospital call per client, per day for the same or related diagnoses. The Department does not pay separately for the hospital call if it is included in the global surgery payment. (See the Surgical Services Section for information on global surgery policy.)

- Professional inpatient services (CPT codes 99221-99223) during the global surgery follow-up period only if they are performed on an emergency basis and are unrelated to the original surgery. Use modifier 24 to indicate that the service is unrelated to the original surgery.

Note: The Department pays providers for CPT codes 99221-99223 for scheduled hospital admissions during the follow-up period only when billed with a modifier 24.

The Department does not cover:

- A hospital admission (CPT codes 99221-99223) and a planned surgery billed in combination. The hospital admission is included in the global fee for the surgery.

- Inpatient or observation care services [including admission and discharge services (CPT codes 99234-99236)] for stays of less than 8 hours on the same calendar date.

Other Guidelines:

- When a hospital admission (CPT codes 99221-99223) and an emergency surgery is billed in combination, the Department will pay when there is a decision to do surgery, the provider has not seen the client for this condition, and modifier 57 is used. This only applies to surgical procedures with a 90-day global period.

- When a client is admitted for observation care for less than 8 hours and is discharged on the same calendar date, providers must bill using CPT codes 99218-99220. The Department does not pay providers separately for discharge services.

- When a client is admitted for observation care and is discharged on a different calendar date, providers must bill using CPT codes 99218-99220 **and** observation discharge CPT code 99217.

- When a client qualifies for an inpatient hospital admission and is discharged on a different calendar date, providers must bill using CPT codes 99221-99233 **and** hospital discharge day management CPT code 99238 or 99239.

- When a client qualifies for an inpatient hospital admission and is discharged on the same calendar date, providers must bill using CPT codes 99234-99236. The Department does not pay providers separately for hospital discharge day management services.

- Providers must satisfy the documentation requirements for both admission to and discharge from, inpatient or observation care in order to bill CPT codes 99234-99236. The length of time for observation care or treatment status must also be documented.

- When clients are fee-for-service (FFS) when admitted to a hospital and then enroll in a Department managed care organization during the hospital stay, the entire stay for physician services is paid FFS until the client is discharged. Enter the following on the claim:

  ✓ The admission date to the hospital; and
  ✓ "Continuous hospital care" (in the *claim notes* field).

Utilization Review

Utilization Review (UR) is a concurrent, prospective, and/or retrospective (including post-pay and pre-pay) formal evaluation of a client's documented medical care to assure that the healthcare services provided are proper and necessary and are of good quality. The review considers the appropriateness of the place of care, level of care, and the duration, frequency, or quantity of healthcare services provided in relation to the condition(s) being treated. The Department uses InterQual ISDR Level of Care criteria as a guideline in the utilization review process.

- Concurrent UR is performed during a client's course of care.
- Prospective UR is performed prior to the provision of healthcare services.
- Retrospective UR is performed following the provision of healthcare services and includes both post-payment and pre-payment review.
- Post-payment retro UR is performed after healthcare services are provided and paid.
- Pre-payment retro UR is performed after healthcare services are provided but prior to payment.

Detoxification Services

The Department covers detoxification services for clients receiving alcohol and/or drug detoxification services in a Department-enrolled hospital-based detoxification center or in an acute care hospital when the following conditions are met:

- The stay meets the intensity of service and severity of illness standards necessary to qualify for an inpatient hospital stay;
- The care is provided in a medical unit;
- The client is not participating in the Department's Chemical-Using Pregnant (CUP) Women program;
- Inpatient psychiatric care is not medically necessary and an approval from the Regional Support Network (RSN) is not appropriate; and
- Nonhospital-based detoxification is not medically appropriate.

Note: Physicians must indicate the hospital's NPI in field 32 on the CMS-1500 Claim Form or in the *Comments* field when billed electronically (field 32 on the CMS-1500 form). If the hospital's NPI is not indicated on the claim, the claim will be denied.

When the conditions on the previous page are met, providers must bill as follows:

Procedure Code	Modifier	Brief Description	Limitations
H0009		Alcohol and/or drug services [*bill for the initial admission*]	Limited to one per hospitalization. Restricted to ICD-9-CM diagnosis codes 292.0-292.9, 303.00-305.03, 305.20-305.93, and 790.3
H0009	TS	Alcohol and/or drug services with follow-up service modifier [*bill for any follow-up days*]	

Note: Managed Care Clients who are receiving detoxification services in a detox hospital that has a detoxification-specific taxonomy can be billed directly to the Department.

Smoking Cessation

Smoking Cessation, which can include free counseling and prescription drugs, represents a major advancement in public health for Washington State. Below is a brief overview of the way the benefit works and the services available for clients in the Department fee-for-service program. For clients enrolled in managed care, contact the client's health plan for information regarding the smoking cessation benefit.

What services are available?

Refer clients to the toll-free Washington State Tobacco Quit Line for one or more of the following free services:

- Telephone counseling and follow-up support calls through the quit line;
- Nicotine patches or gum through the quit line, if appropriate; and
- Prescription medications recommended by the quit line. The client will then be referred back to their provider for a prescription, if appropriate.

The Washington State Tobacco Quit Line is:

1-800-QUIT-NOW (1-800-784-8669)	English
1-877-2NO-FUME (1-877-266-3863)	Spanish

Who is eligible to receive these services?

- All medical assistance clients 18 years of age and older and all pregnant women regardless of age are eligible for smoking cessation services through the Tobacco Quit Line.

- Clients eligible for the Alien Emergency Medical (AEM) program or enrolled in the Family Planning Only or TAKE CHARGE programs are eligible for some of the above mentioned services; however, these clients **are not eligible** for prescription drugs and smoking cessation services provided by their primary care provider.

When a client is receiving counseling from the Tobacco Quit Line, the Tobacco Quit Line may recommend a smoking cessation prescription, if appropriate. The client will return to the provider's office with a form for you to review. Complete the form and fax it with a prescription to the Department (see the *Important Contacts* section).

When will the Department pay for a smoking cessation referral?

The Department will pay physicians and ARNP's for a smoking cessation referral (**T1016**) when:

- The client is pregnant or 18 years of age and older;

- The client presents a Services Card and is covered by a Benefit Services Package.

> **Note:** Refer to the *Scope of Healthcare Services Table* web page at: http://hrsa.dshs.wa.gov/Download/ScopeofHealthcareSvcsTable.html for an up-to-date listing of Benefit Service Packages.

- The client is **not** eligible for the **AEM** program or enrolled in the **Family Planning Only or TAKE CHARGE** program;

- The referral is billed with ICD-9-CM diagnosis 305.1, 649.03, or 649.04;

- The client is evaluated, in person, for the sole purpose of counseling the client to encourage them to call and enroll in this smoking cessation program; **and**

- The referral is not billed in combination with an evaluation and management office visit.

When will the Department pay for a smoking cessation referral for an evaluation for a smoking cessation prescription?

The Department will pay physicians and ARNP's for a smoking cessation referral (**T1016**) for an evaluation for a smoking cessation prescription when:

- The client is pregnant or 18 years of age or older;
- The client is enrolled in this smoking cessation program;
- The client presents a Services Card and is covered by a Benefit Services Package.

> **Note:** Refer to the *Scope of Healthcare Services Table* web page at: http://hrsa.dshs.wa.gov/Download/ScopeofHealthcareSvcsTable.html for an up-to-date listing of Benefit Service Packages.

- The client is **not** eligible for the **AEM** program or enrolled in the **Family Planning Only or TAKE CHARGE** program;
- The referral is billed with ICD-9-CM diagnosis 305.1, 649.03, or 649.04;
- Evaluate the client for a smoking cessation prescription, with or without the client present, complete the form, and fax it to the Department Pharmacy Authorization Section, Drug Use and Review; **and**
- The referral is not billed in combination with an evaluation and management office visit.

Additional information:

- For more information about the smoking cessation benefit, call the Department at 1-800-562-3022.
- For more information about the Tobacco Quit Line, visit www.Quitline.com.
- To order brochures and business cards, go to http://www.tobaccoprc.org/TCRC.

Emergency Physician-Related Services (CPT codes 99281-99285)

[Refer to WAC 388-531-0500]

- For services performed by the physician assigned to, or on call to, the emergency department, bill the Department using CPT codes 99281-99285.

> **Note**: For multiple emergency room (ER) visits on the same day with related diagnoses, the time(s) of the additional visit(s) must be noted in the *Comments* section of the claim form.

- The Department does not pay emergency room physicians for hospital admissions (e.g., CPT codes 99221-99223) or after-hours services (e.g., CPT codes 99050 and 99053).

- Physicians who perform emergency room services **must not** bill modifier 54 when billing the Department for surgical procedures.

- Physicians who provide only the follow-up services for minor procedures performed in emergency departments must bill the appropriate level of office visit code without modifier 55.

- The Department follows Medicare's policy to not pay emergency room providers for the following procedure codes: CPT codes 96360-96361 or 96365-96368.

End-Stage Renal Disease (ESRD)

Inpatient Visits for Hemodialysis or Outpatient Non-ESRD Dialysis Services
(CPT codes 90935 and 90937)

Procedure Codes Billed	Instructions
90935 and 90937	Bill these codes for the hemodialysis procedure with all E&M services related to the client's renal disease on the day of the hemodialysis procedure. Bill these codes for the following clients: • Clients in an inpatient setting with ESRD; or • Clients receiving hemodialysis in an outpatient or inpatient setting who do not have ESRD. **Bill using ICD-9-CM diagnosis code 585.6 or the appropriate diagnosis code (584.5-586) for clients requiring dialysis but who do not have ESRD.**
90935	Bill using procedure code 90935 if only one evaluation is required related to the hemodialysis procedure.
90937	Bill using procedure code 90937 if a re-evaluation(s) is required during a hemodialysis procedure on the same day.

Inpatient Visits for Dialysis Procedures Other Than Hemodialysis (e.g., peritoneal dialysis, hemofiltration, or continuous renal replacement therapies)
(CPT codes 90945, 90947)

Procedure Codes Billed	Instructions
90945 and 90947	Bill these codes for E&M services related to the client's renal disease on the day of the procedure that includes peritoneal dialysis, hemofiltration, or continuous renal replacement. **Bill using ICD-9-CM diagnosis code 585.6 or the appropriate diagnosis code (584.5-586) for clients requiring dialysis but who do not have ESRD.**
90945	Bill using procedure code 90945 if only one evaluation is required related to the procedure.
90947	Bill using procedure code 90947 if a re-evaluation(s) is required during a procedure on the same day.

If a separately identifiable service is performed on the same day as a dialysis service, you may bill any of the following E&M procedures codes with modifier 25:

- 99201-99205 Office or Other Outpatient Visit: New Patient;
- 99211-99215 Office or Other Outpatient Visit: Established Patient;
- 99221-99223 Initial Hospital Care: New or Established Patient;
- 99238-99239 Hospital Discharge Day Management Services;
- 99241-99245 Office or Other Outpatient Consultations: New or Established Patient; and
- 99291-99292 Critical Care Services.

Critical Care (CPT codes 99291-99292) [Refer to WAC 388-531-0450]

Note: For neonatal or pediatric critical care services, see page B.19.

What is critical care?

Critical care is the direct delivery and constant attention by a provider(s) for a critically ill or critically injured patient. A critical illness or injury acutely impairs one or more vital organ systems such that there is a high probability of imminent or life threatening deterioration in the patient's condition.

Critical care involves high complexity decision making to assess, manipulate, and support vital system function(s); to treat single or multiple vital organ system failure; and/or to prevent further life threatening deterioration of the patient's condition.

Providing medical care to a critically ill, injured, or postoperative patient qualifies as a critical care service only if both the illness or injury and the treatment being provided meet the above requirements. Critical care is usually, but not always, given in a critical care area, such as the coronary care unit, intensive care unit, pediatric intensive care unit, respiratory care unit, or the emergency care facility. Services for a patient who is not critically ill but happens to be in a critical care unit are reported using other appropriate E&M codes.

Billing for Critical Care

When billing for critical care, providers must bill using CPT codes 99291-99292:

- For the provider's attendance during the transport of critically ill or critically injured clients 25 months of age or older to or from a facility or hospital.

- To report critical care services provided in an outpatient setting (e.g., Emergency department or office), for neonates and pediatric clients up through 24 months.

- To report the total duration of time spent by a physician providing critical care services to a critically ill or critically injured client, even if the time spent by the physician on that date is not continuous. For any given period of time spent providing critical care services, the physician must devote his or her full attention to the client and cannot provide services to any other patient during the same period of time.

Note: Surgery, stand-by, or lengthy consultation on a **stable** client does not qualify as critical care.

Where is critical care performed?

Critical care is usually performed in a critical care area of a hospital, such as a(n):

- Coronary care unit;
- Intensive care unit;
- Respiratory care unit; or
- Emergency care facility.

The Department covers:

- A maximum of three hours of critical care per client, per day.
- Critical care provided by the attending physician who assume(s) responsibility for the care of a client during a life-threatening episode.
- Critical care services provided by more than one physician if the services involve multiple organ systems (unrelated diagnosis). However, in the emergency room, payment for critical care services is limited to one physician.

The following services (with their corresponding CPT codes) are included in critical care. Do not bill these separately:

- Vascular access procedures (36000, 36410, 36415, 36591, and 36600);
- Gastric intubation (43752 and 91105);
- Chest x-rays (71010, 71015, and 71020);
- Temporary transcutaneous pacing (92953);
- The interpretation of cardiac output measurements (93561-93562);
- Ventilator management (94002-94004, 94660, and 94662);

- Pulse oximetry (94760 and 94762); or
- Blood gases, and information data stored in computers (e.g., ECGs, blood pressures, hematologic data) (99090).

> **Note:** Procedure code 43752 may be billed separately when it is the only procedure code billed.

Physician Standby Services (CPT code 99360)

[Refer to WAC 388-531-1250]

The Department covers physician standby services when those services are requested by another physician and involve prolonged physician attendance without direct (face-to-face) client contact.

> **Note:** The standby physician cannot provide care or services to other clients during the standby period.

Limitations

- Standby services of less than 30 minutes are not covered.
- After the first 30 minutes, subsequent periods of standby services are covered only when a full 30 minutes of standby is provided for each unit billed.

The Department does not cover physician standby services when:

- The provider performs a surgery that is subject to the "global surgery policy" (refer to Section F);
- Billed in addition to any other procedure code, with the exception of CPT codes 99460 and 99465; or
- When the service results in an admission to a neonatal intensive care unit (CPT 99468) on the same day.

Prolonged Services (CPT codes 99354-99357) [Refer to WAC 388-531-1350]

The Department covers prolonged services:

- Up to three hours per client, per diagnosis, per day.

> **Note:** The time counted toward payment for prolonged E&M services includes only direct face-to-face contact between the provider and the client, whether or not the services were continuous.

- Only when the provider performs one of the services listed below for the client on the same day:

Prolonged CPT Code	Other CPT Code(s)
99354	99201-99215, 99241-99245, 99304-99350
99355	99354 and one of the E&M codes required for 99354
99356	99221-99233, 99251-99255,
99357	99356 and one of the E&M codes required for 99356

> **Note:** Both the prolonged services CPT code ***and*** any of the "Other CPT Codes" listed above **must** be billed on the **same** claim.

Osteopathic Manipulative Therapy (CPT codes 98925-98929)
[Refer to WAC 388-531-1050]

The Department covers:

- Ten (10) osteopathic manipulations per client, per calendar year.
- Osteopathic Manipulative Therapy (OMT) services only when provided by an osteopathic physician licensed under chapter 18.71 RCW.
- OMT services by body regions. Body regions are defined as:

✓ abdomen and viscera	✓ pelvic
✓ cervical	✓ rib cage
✓ head	✓ sacral
✓ lower extremities	✓ thoracic
✓ lumbar	✓ upper extremities

- One OMT procedure code in the range 98925-98929 per client, per day. Bill using the CPT code that describes the number of body regions involved. For example, if three body regions are manipulated, bill one unit of CPT code 98926.

- An E&M service (billed with modifier 25) in addition to the OMT, under one of the following circumstances:

  ✓ When a provider diagnoses the condition requiring OMT and provides the therapy during the same visit;

  ✓ When the existing condition fails to respond to OMT or significantly changes, requiring E&M services beyond those considered included in the manipulation codes; or

  ✓ When the provider treats the client for a condition unrelated to the OMT during the same encounter.

  Justification for the E&M and OMT services must be documented and retained in the client's record for review.

Note: The Department **does not cover** physical therapy services performed by osteopathic physicians unless they are also physiatrists.

Newborn Care

To assist providers in billing CPT codes with "newborn" in the description, the Department defines a newborn as 28 days old or younger.

The Department covers:

- One newborn evaluation per newborn when they are not discharged on the same day using either CPT code 99460 for hospital or birthing center or 99461 for home births.

- Subsequent hospital care (other than initial evaluation or discharge) using CPT code 99462.

- One newborn evaluation and discharge per newborn performed in the hospital or birthing center on the same day using CPT code 99463.

Note: The Department covers circumcisions (CPT codes 54150, 54160, and 54161) ***only*** with medical ICD-9-CM diagnosis codes 605 (Phimosis), 607.1 (Balanoposthitis), or 607.81 (Balanitis Xerotica).

Neonatal Intensive Care Unit (NICU)/ Pediatric Intensive Care Unit (PICU) (CPT codes 99468-99480)

[Refer to WAC 388-531-0900]

NICU/PICU care includes management, monitoring, and treatment of the neonate/infant including respiratory, pharmacological control of the circulatory system, enteral and parenteral nutrition, metabolic and hematological maintenance, parent/family counseling, case management services, and personal direct supervision of the health care team's activities.

The Department covers:

- One NICU/PICU service per client, per day.
- Intensive observation, frequent interventions, and other intensive services for neonates. Use CPT code 99477 for initial hospital care, per day, when a neonate requires intensive observation, frequent interventions and other intensive services. You may report 99460 and 99477 when two distinct services are provided on the same day, but you must use modifier 25 with 99460. Bill 99460 with modifier 25 when you see a normal newborn after an uneventful delivery and then later the infant develops complications and is transferred to an intensive setting for observation, frequent interventions, and other intensive services.
- NICU/PICU services when directing the care of a neonate/infant in a NICU/PICU. These codes represent care beginning with the date of admission to the NICU/PICU.

  Note: Once the infant is no longer considered critically ill, hospital care CPT codes 99231-99233 (>2500 grams) or 99478-99480 (<2500 grams) must be used.

- Newborn resuscitation (CPT code 99465) in addition to NICU/PICU services.
- The provider's attendance during the transport of critically ill or critically injured pediatric clients 24 months of age or younger to or from a facility or hospital (CPT code 99466 or 99467).
- Codes 99291-99292 for critical care services provided in an outpatient setting when the client is 24 months of age or younger.

The following services and the subsequent intensive, noncritical services (with their corresponding CPT codes) are included in neonatal or pediatric critical care. Do not bill these separately:

- Bladder catheterization (51701- 51702);
- Central (36555) or peripheral vessel catheterization (36000);
- Continuous positive airway pressure (CPAP) (94660);
- Endotracheal intubation (31500);
- Initiation and management of mechanical ventilation (94002-94004);
- Invasive or noninvasive electronic monitoring of vital signs, bedside pulmonary function testing (94375), and/or monitoring or interpretation of blood gases or oxygen saturation (94760-94762);
- Lumbar puncture (62270);
- Oral or nasogastric tube placement (43752);
- Other arterial catheters (36140 and 36620);
- Umbilical arterial catheterization (36660);
- Umbilical venous catheterization (36510);
- Suprapubic bladder aspiration (51100);
- Surfactant administration, intravascular fluid administration (96360, 96361, 90780, and 90781);
- Transfusion of blood components (36430 and 36440);
- Vascular punctures (36420 and 36600); or
- Vascular access procedures (36400, 36405, and 36406).

Note: Procedure code 43752 may be billed separately when it is the only procedure code billed.

Intensive (Noncritical) Low Birth Weight Services (99478-99480)

- Bill the appropriate procedure codes only once per day, per client.
- These codes represent care that begins subsequent to the admission date.

Physician Care Plan Oversight (CPT codes 99375, 99378, and 99380)

[Refer to WAC 388-531-1150]

The Department covers:

- Physician care plan oversight services once per client, per month.
  - ✓ A plan of care must be established by the home health agency, hospice, or nursing facility.
  - ✓ The provider must perform 30 or more minutes of oversight services for the client each calendar month.

The Department does not cover:

- Physician care plan oversight services of less than 30 minutes per calendar month (CPT codes 99374, 99377, and 99379).
- Physician care plan oversight services provided by more than one provider during the global surgery payment period, unless the care plan oversight is unrelated to the surgery.

Physicians Providing Service to Hospice Clients

The Department pays for hospice care for eligible clients. To be eligible, clients must be certified by a physician as terminally ill with a life expectancy of six months or less. Contact your local hospice agency and they will evaluate the client. Hospice will cover all services required for treatment of the terminal illness. These services must be provided by or through the hospice agency.

The Department pays providers who are attending physicians and not employed by the hospice agency:

- For direct physician care services provided to a hospice client;
- When the provided services are not related to the terminal illness; and
- When the client's provider, including the hospice provider, coordinates the health care provided.

When billing, primary physicians must put their NPI in field 33 of the CMS-1500 Claim Form. When billing, the consulting physician, other than the primary physician, must put the following on the CMS-1500 Claim Form:

- The primary physician name or clinic name and NPI the referring provider field of the HIPAA transaction (field 17 and 17a of the CMS-1500); and

- The consulting physician's performing NPI (PIN#) in the servicing provider field of the HIPAA transaction (field 24k of the CMS-1500) and group NPI (GRP#) in the pay-to provider number field of the HIPAA transaction (field 33 of the CMS-1500).

If not related to hospice care, when billing electronically, enter "Not related to hospice care" in the claim notes field of the HIPAA transaction.

Domiciliary, Rest Home, or Custodial Care Services

CPT codes 99304-99318 are ***not*** appropriate E&M codes for use in place of service 13 (Assisted Living) or 14 (Group Home). Providers must use CPT codes 99324-99328 or 99334-99337 for E&M services provided to clients in these settings.

Home Evaluation and Management

The Department pays for Home Evaluation and Management (CPT codes 99341-99350) only when services are provided in place of service 12 (home).

Telehealth

What is telehealth?

Telehealth is when a health care practitioner uses interactive real-time audio and video telecommunications to deliver covered services that are within his or her scope of practice to a client at a site other than the site where the provider is located.

Using telehealth when it is medically necessary enables the health care practitioner and the client to interact in real-time communication as if they were having a face-to-face session. Telehealth allows Department clients, particularly those in medically underserved areas of the state, improved access to essential health care services that may not otherwise be available without traveling long distances.

The following services are ***not*** covered as telehealth:

- Email, telephone, and facsimile transmissions;
- Installation or maintenance of any telecommunication devices or systems;
- Home health monitoring; or
- "Store and forward" telecommunication based services. (Store and forward is the asynchronous transmission of medical information to be reviewed at a later time by the physician or practitioner at the distant site).

Who is eligible for telehealth?

Fee-for-service clients are eligible for medically necessary covered health care services delivered via telehealth. The referring provider is responsible for determining and documenting that telehealth is medically necessary. As a condition of payment, the client must be present and participating in the telehealth visit.

The Department will not pay separately for telehealth services for clients enrolled in a managed care plan. Clients enrolled in a Department managed care plan are identified as such in ProviderOne. Managed care enrollees must have all services arranged and provided by their primary care providers (PCP). Contact the managed care plan regarding whether or not the plan will authorize telehealth coverage. It is not mandatory that the plan pay for telehealth.

When does the Department cover telehealth?

The Department covers telehealth through the fee-for-service program when it is used to substitute for a face-to-face, "hands on" encounter for only those services specifically listed in this section.

Originating Site (Location of Client)

What is an "originating site"?

An originating site is the physical location of the eligible Department client at the time the professional service is provided by a physician or practitioner through telehealth. Approved originating sites are:

- The office of a physician or practitioner;
- A hospital;
- A critical access hospital;
- A rural health clinic (RHC); and
- A federally qualified health center (FQHC).

Is the originating site paid for telehealth?

Yes. The originating site is paid a facility fee per completed transmission.

How does the originating site bill the Department for the facility fee?

- *Hospital Outpatient*: When the originating site is a hospital outpatient department, payment for the originating site facility fee will be paid according to the maximum allowable fee schedule. To receive payment for the facility fee, outpatient hospital providers must bill revenue code 0789 on the same line as HCPCS code Q3014.

- *Hospital Inpatient*: When the originating site is an inpatient hospital, there is no payment to the originating site for the facility fee.

- *Critical Access Hospitals*: When the originating site is a critical access hospital outpatient department, payment is separate from the cost-based payment methodology. To receive payment for the facility fee, critical access hospitals must bill revenue code 0789 on the same line as HCPCS code Q3014.

- *FQHCs and RHCs*: When the originating site is an FQHC or RHC, bill for the facility fee using HCPCS code Q3014. This is not considered an FQHC or RHC service and is not paid as an encounter, and is not reconciled in the monthly gross adjustment process.

- *Physicians' Offices*: When the originating site is a physician's office, bill for the facility fee using HCPCS code Q3014.

If a provider from the originating site performs a separately identifiable service for the client on the same day as telehealth, documentation for both services must be clearly and separately identified in the client's medical record.

Distant Site (Location of Consultant)

What is a "distant site"?

A distant site is the physical location of the physician or practitioner providing the professional service to an eligible Department client through telehealth.

Who is eligible to be paid for telehealth services at a distant site?

The Department pays the following provider types for telehealth services provided within their scope of practice to eligible Department clients:

- Physicians (including Psychiatrists); and
- Advanced Registered Nurse Practitioners (ARNPs).

What services are covered using telehealth?

Only the following services are covered using telehealth:

- Consultations (CPT codes 99241–99245 and 99251-99255);
- Office or other outpatient visits (CPT 99201-99215);
- Psychiatric intake and assessment (CPT code 90801);
- Individual psychotherapy (CPT codes 90804-90809); and
- Pharmacologic management (CPT codes 90862).

> **Note**: Refer to other sections of these billing instructions for specific policies and limitation on these CPT codes.

How does the distant site bill the Department for the services delivered through telehealth?

The payment amount for the professional service provided through telehealth by the provider at the distant site is equal to the current fee schedule amount for the service provided.

Use the appropriate CPT codes **with modifier GT** (via interactive audio and video telecommunications system) when submitting claims to the Department for payment.